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BHM HEALTHCARE SOLUTINS
INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 07/31/2017

IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
EMG Left Lower Extremity
NCV Right Lower Extremity
NCV Left Lower Extremity
EMG Right Lower Extremity

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Certified Internal Medicine

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
IRO Referral, Denial Letters and available Medical Information

PATIENT CLINICAL HISTORY:
According to the documentation provided for this review, the patient is a female with a date of birth XXXX and a date of injury listed as XXXX. The patient reportedly sustained a lower back injury XX. The patient reported XXXXX on the date of injury. The patient's injury has been treated with physical therapy X 12 visits for the thoracic spine and physical therapy X6 visits for the bilateral shoulders. The patient has also been treated with medications. The denied services are EMG/NCV of bilateral lower extremities and EMG/NCV of the bilateral upper extremities. A provider note on XXXX indicates the patient continues to have pain in shoulders bilaterally. The patient indicated that Flexeril made her drowsy. Physical exam was notable for tenderness of the bilateral shoulders. The recommendations were for continuation of physical therapy and an order was placed for MRI of the left shoulder. An office note dated XXXX documents the patient's having continued complaints of bilateral shoulder pain, right greater than left. Examination was

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notable for tenderness in both shoulder joints with right shoulder strength 3+/5 for flexion, extension, internal rotation, and external rotation with 3/5 abduction. Examination of the knee revealed mild tenderness of the knee joint and mildly decreased range of motion. Examination of the right leg revealed mild tenderness of the tibia upon palpation. The provider recommended EMG/NCV of the bilateral upper extremities and lower extremities.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The documentation provided does not support the medical necessity of the requested EMG/NCV of the bilateral upper and lower extremities. The documentation does indicate the patient has red-flag signs or symptoms, neurological deficits, or functional limitations that would indicate the need for the requested study. The guidelines do not support the use of the requested study without significant findings or suspicion of pathologic disease based on physical exam, worsening symptoms, or other red-flag signs or symptoms necessitating the requested study. There are no documented extenuating circumstances that would necessitate coverage of the request outside of guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**